STATEMENT OF CARE AND RESPONSIBILITY FOR BENEFICIARY

NAME AND ADDRESS OF CUSTODIAN	In replying, use this address: SOCIAL SECURITY ADMINISTRATION
	TELEPHONE NUMBER
	DATE
	SSA CONTACT

Sections 205(a) and 205(j) of the Social Security Act allow us to ask for the information on this form. Although responses to these questions are voluntary, the information you provide is needed to establish an applicant's suitability to serve as representative payee.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

IDENTIFYING INFORMATION
(If different from patient)

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON

SOCIAL SECURITY NUMBER

APPLICANT'S NAME AND ADDRESS	BENEFICIARY NAME
	BENEFICIARY SOCIAL SECURITY NUMBER
	APPLICANT'S RELATIONSHIP TO BENEFICIARY

YOUR HELP IS NEEDED

The applicant shown above has applied to be appointed representative payee for the above beneficiary. We need you to complete this form and return it to us in the enclosed envelope. The information you provide will help us decide if we should pay this person directly or if he or she needs a representative payee to handle funds. If a representative payee is needed, you will help us to determine the responsibility assumed by the applicant for the beneficiary's well-being. Thank you for your help.

1. DATE BENEFICIARY BEGAN LIVING WITH YOU (month/day/year)	HOW LONG WILL BENEFICIARY LIVE WITH YOU?	REASON BENEFICIARY DOES NOT LIVE WITH THE APPLICANT

2. If the beneficiary is not living with you, where and with whom is the beneficiary living and when did he or she leave your care?

3. Do you believe the beneficiary is capable of managing or directing the management of benefits in his or her own best interest?

By capable we mean the beneficiary:

- Is able to understand and act on the ordinary affairs of life, such as providing for own food, housing, clothing, etc., and
- Is able, in spite of physical impairments, to manage funds or direct others how to manage them.

☐ YES ☐ NO ☐ UNSURE

If "NO" or "Unsure," please provide a brief explanation.

4. Please show the approximate amount you charge each month for the beneficiary's room, board, and care →	PER MONTH $

5. Does (or did) any agency, including the applicant, pay toward the cost of the beneficiary's care and maintenance? ☐ YES ☐ NO

If "Yes," please supply the information requested below.

NAME AND ADDRESS	AMOUNT CONTRIBUTED	HOW OFTEN CONTRIBUTIONS ARE MADE

6. How often and when was the last time the applicant did any of the things shown below for the beneficiary?

	VISIT	SENDS CLOTHING	SENDS OTHER GIFTS	WRITES LETTERS
How often?				
Last Time?				

7. List the names and relationship of any other relatives or close friends who have provided support and/or show interest in the claimant. Describe the type and amount of support and/or how interest is displayed.

NAME	ADDRESS/PHONE NO.	RELATIONSHIP	SUPPORT/INTEREST

8. Does the beneficiary have any unmet personal needs at this time? ☐ YES ☐ NO

If "Yes," please list the needs.

9. In emergency situations, where the beneficiary needs surgery, becomes seriously ill, etc., who would you notify?

NAME	ADDRESS

10. Does the applicant give you any instructions for the care of the beneficiary? ☐ YES ☐ NO

If "Yes," explain what those instructions are, how often they are given, and what the applicant does to see that they are carried out.

REMARKS: (This space may be used for explaining any answers to the questions. If you need more space, attach a separate sheet.)

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law by fine, imprisonment or both. I affirm that all information I have given in this document is true.

PAPERWORK REDUCTION ACT STATEMENT:

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

SIGNATURE OF PERSON MAKING STATEMENT

SIGNATURE (First name, middle initial, last name) (Write in ink)	DATE (Month, day, year)
SIGN HERE ▶	TELEPHONE NUMBER (Include area code)

MAILING ADDRESS (Number and street, Apt. No., P.O. Box, or Rural Route)

CITY AND STATE	ZIP CODE	NAME OF COUNTY (IF ANY)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the individual must sign below, giving their full address.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (No. & Street, City, State & ZIP Code)	ADDRESS (No. & Street, City, State & ZIP Code)

REMARKS: (Continued--If you need more space, please attach a separate sheet)